GUIDE TO THE ON-LINE INCIDENT REPORTING SYSTEM

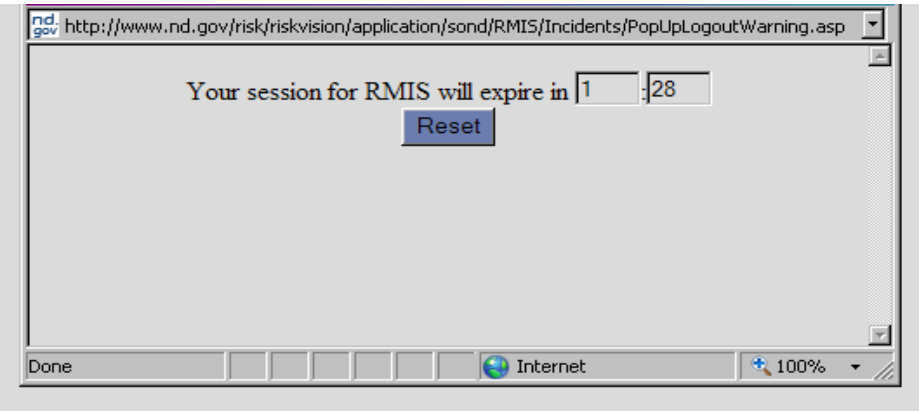
State of North Dakota
Office of Management & Budget
Risk Management Division
July 2008

***Preparation**:* To expedite the reporting process and avoid timing out of the System, make sure you have all of the necessary and required information ready before you start. **Note,** sample forms as they appear in the System, which identify required fields, are located at the end of this Guide.

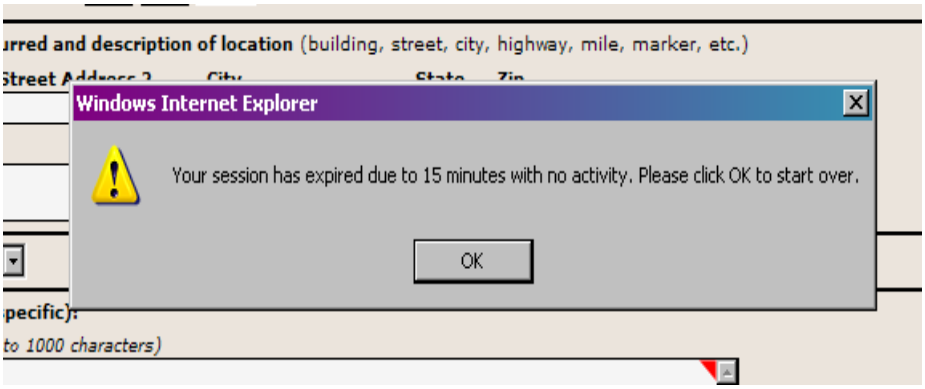
Because the On-Line Incident Reporting System is web-based, Microsoft limits the time a session can be open on the web server. Thus, the time an entry user has to report an incident through the System is also limited. That time is 15-20 minutes. You will be given notice with a **Countdown Timer and Reset** option when that time is about to expire, which will appear as follows:

Countdown Timer & Reset

(1) If the reporting session is open for **15 minutes** without any activity, a message and timer will pop up on the screen, along with a sound chime, giving the user notification that the session will expire in **5 minutes**. This pop up message will give you the option to "**Reset**" the session within the 5 minute time frame. If "**Reset**" is selected, the pop up will close and the session will run for another 15 minutes. The user can continue resetting the session until the report is submitted.

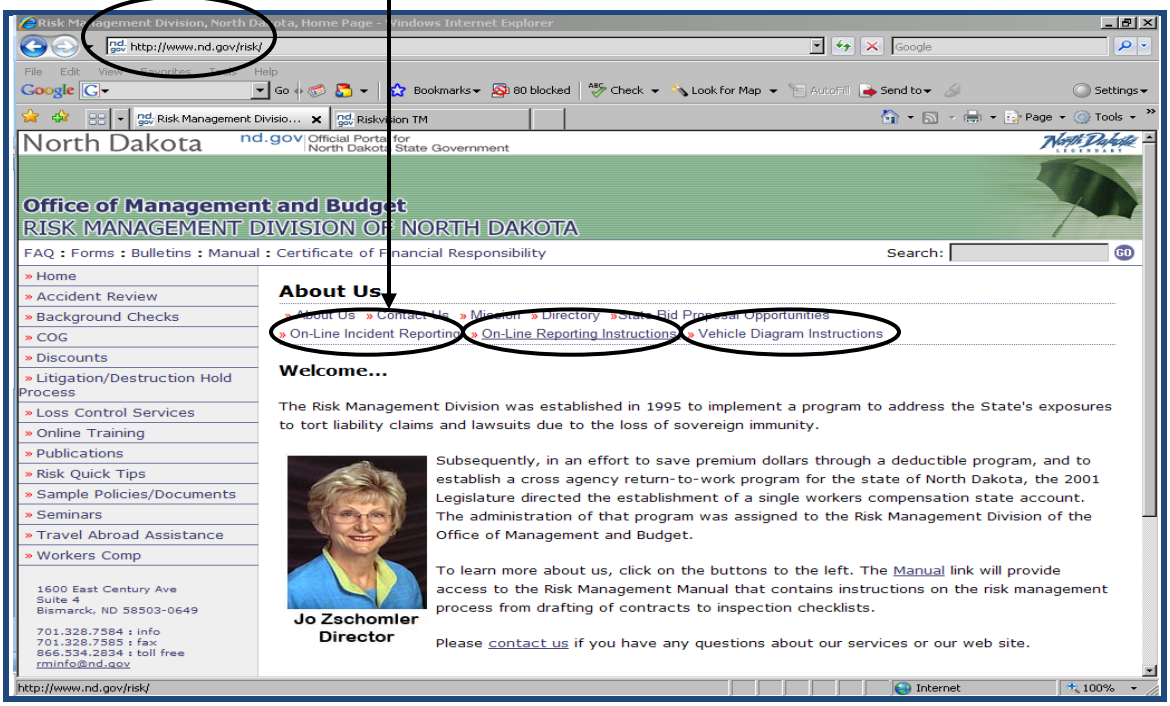


(2) If "**Reset**" is **NOT** selected, a message will pop up explaining that your session expired and you will need to start the reporting session from the beginning.



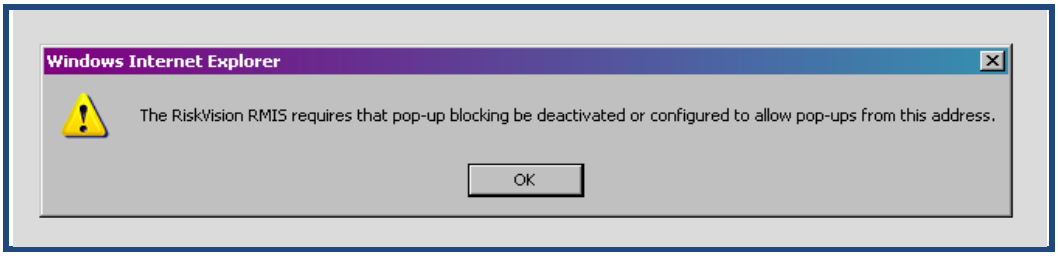
How To Start

- Go to Risk Management's website home page at: **www.nd.gov/risk**
- Click on the **Online Incident Reporting** link.

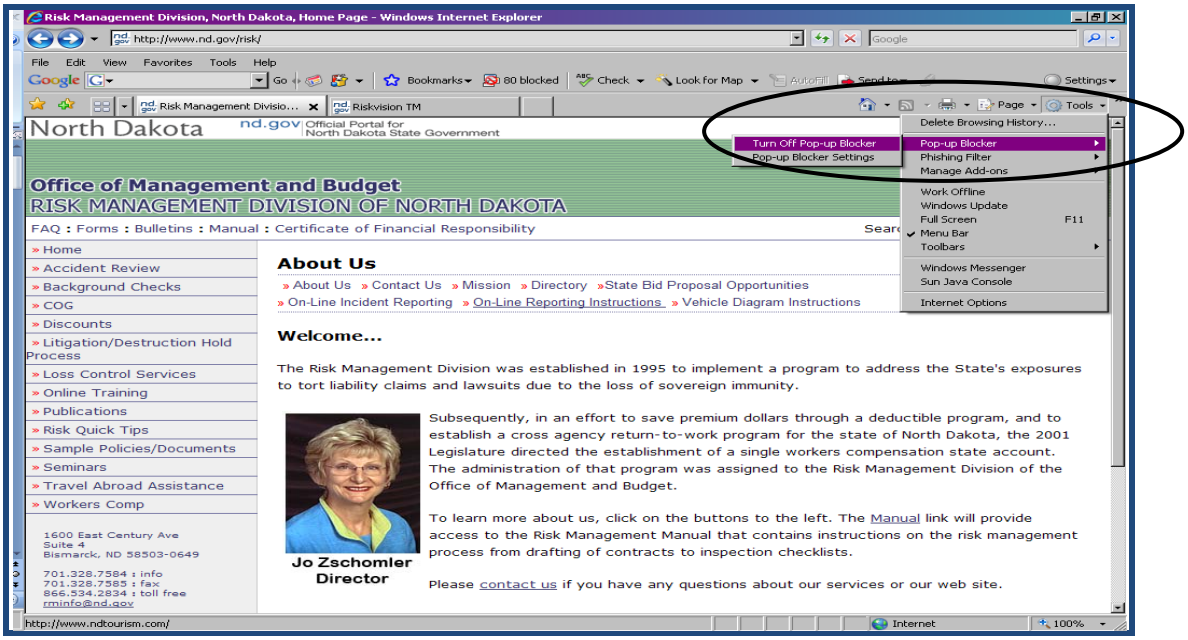


- Then go to ***Click Here to Report An Incident***.

➢ You will get a message about the Pop-up Blocker as follows:

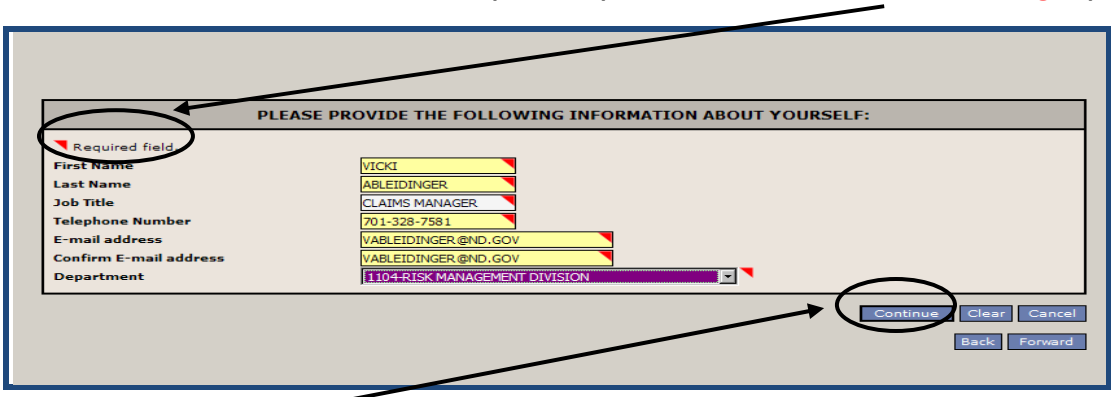


➢ The Pop-up Blocker on your computer **MUST BE** deactivated: Go to (1) Tools, (2) Pop-up Blocker, and (3) Turn Off Pop-up Blocker.



➢ You will get a list and the descriptions of the three different incident reports – click on the report you need to complete based upon the descriptions.

- Type in the information about the person submitting the report – **ALL** fields on this screen are required (identified with a **red triangle**).

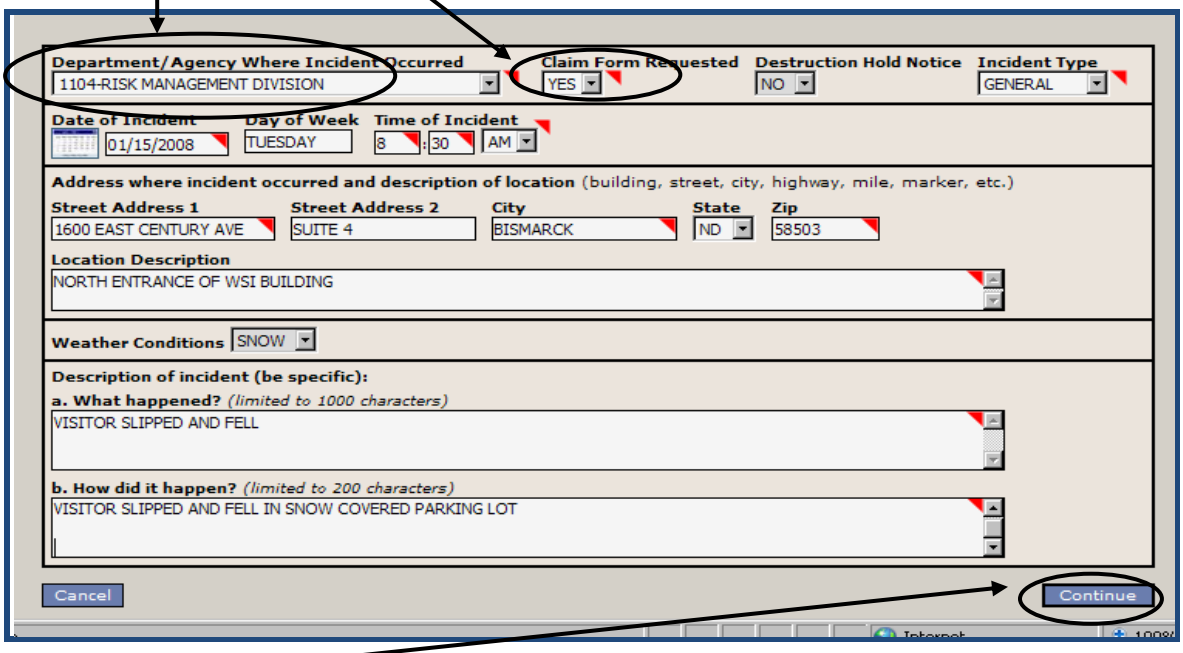


- Click **Continue** when all fields are completed.

- Fill out the necessary information on the first screen. Any field that has a **red triangle** is a required field. If the **Time of Incident** is unknown or cannot be determined type in "**??**" and then choose either AM or PM.

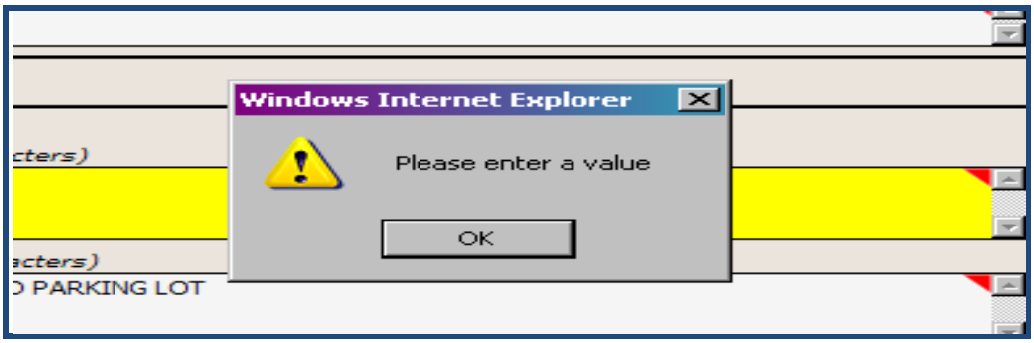
- The **Department/Agency Where Incident Occurred** may differ from the Department identified in the box above; i.e. a Dept. of Human Services employee witnesses an incident that occurred at the Capitol, therefore the 'Agency Where Incident Occurred' is OMB Facility Management.

- Select **Claim Form Requested** if the other party indicates that he/she will be looking for compensation/reimbursement for the incident.



- Click **Continue** after filling in **ALL** the required fields.

- You will get the following message to "Please enter a value" if any of the required fields were missed and are not completed. The particular field will be highlighted in yellow and must be filled in before you can continue to the next screen.



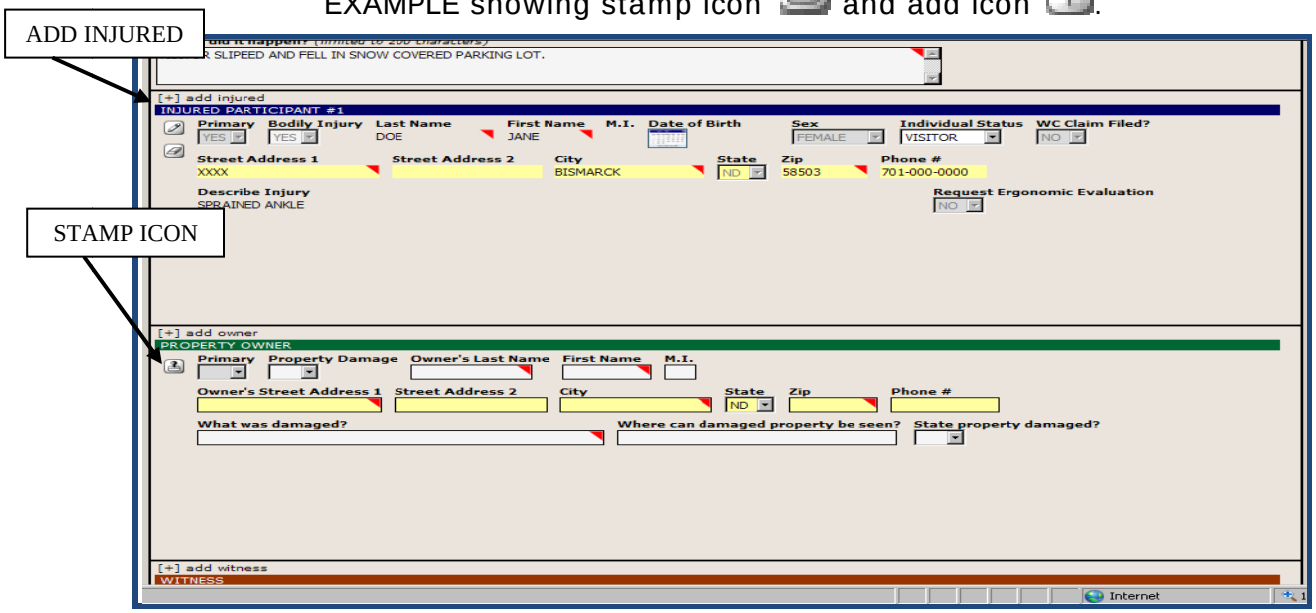
- Fill out the necessary information on the second screen. Remember, any field that has a **red triangle** is a required field. The information that you typed in the first screen will carry over into the second screen.

- When finished entering information about the (a) **Injured Participant (blue section)**, (b) **Property Owner (green section)** and/or (c) **Witness (red section)**, you **MUST** click on the ***stamp icon*** on the left side to save each section.

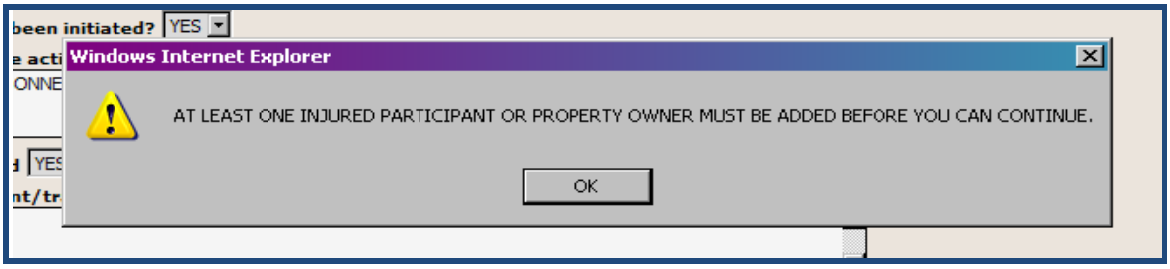
- Either the **Injured Participant (blue)** and/or **Property Owner (green)** must be filled out or the form will not submit. However, both sections do not need to be completed to submit.

- If you need to add more than one individual into these sections, click on the (a) **add injured**, (b) **add owner**, or (c) **add witness**. This option eliminates re-entry of the same incident if multiple parties are involved. It is located at the top of each the blue, green, and red section.

EXAMPLE showing stamp icon and add icon .



- You will get the following message if **(a)** you do not enter an injured participant or property owner and/or **(b)** you do not select the stamp icon, even if information has been entered.

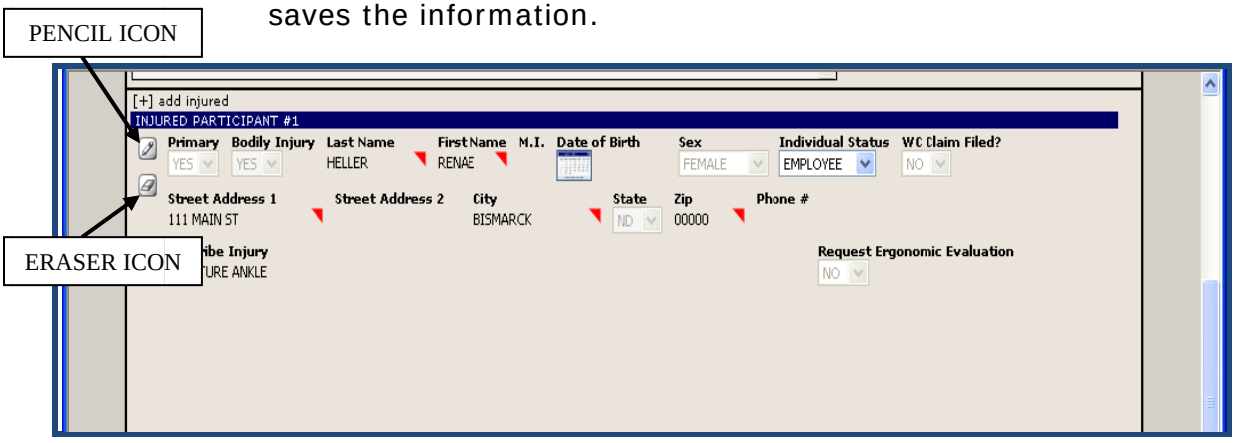


- If you get the message above and you do not correct the error**,** the report will not submit properly and you will need to re-enter the incident.

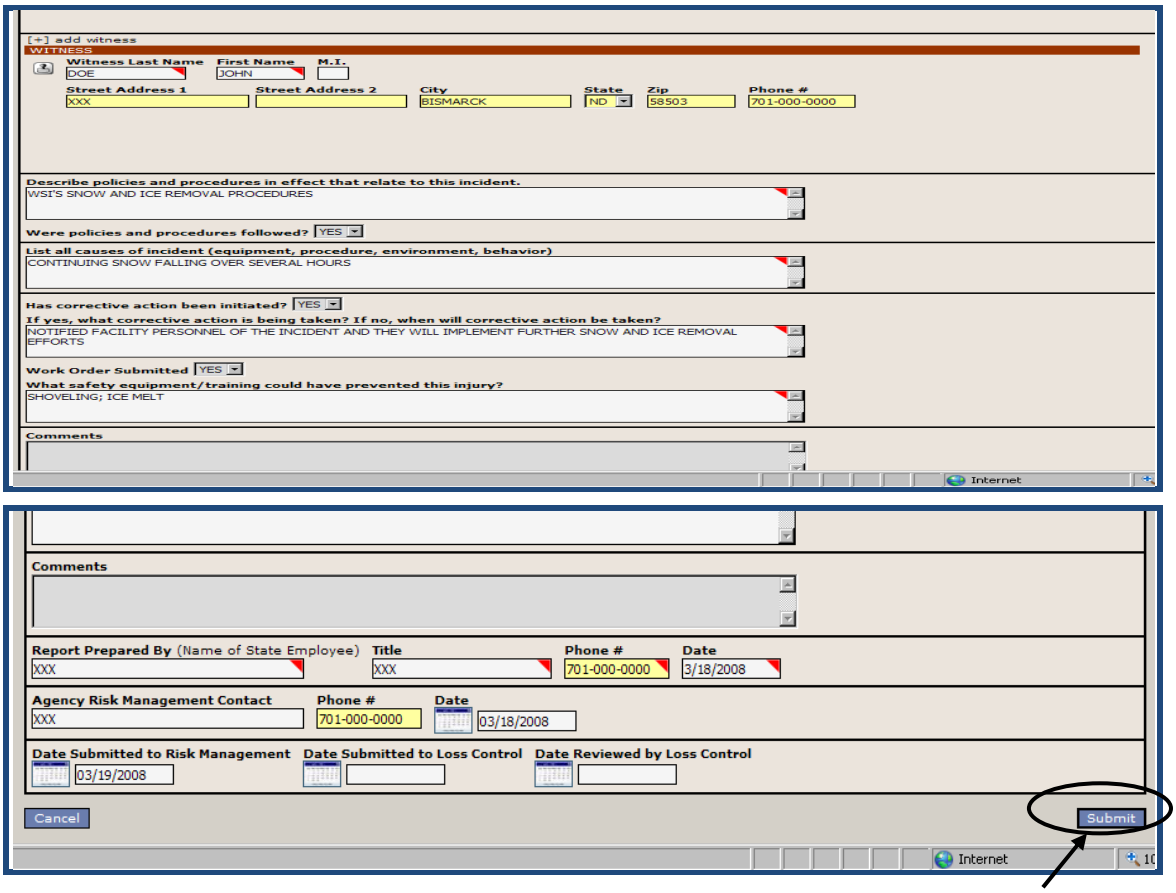
- If you need to make any changes after saving the information, you can either click on the ***pencil icon*** to edit data or the ***eraser icon*** to delete data.

EXAMPLE showing pencil and eraser icon which show up after the data is saved with the stamp icon.

- Note that the fields appear different after the stamp icon saves the information.

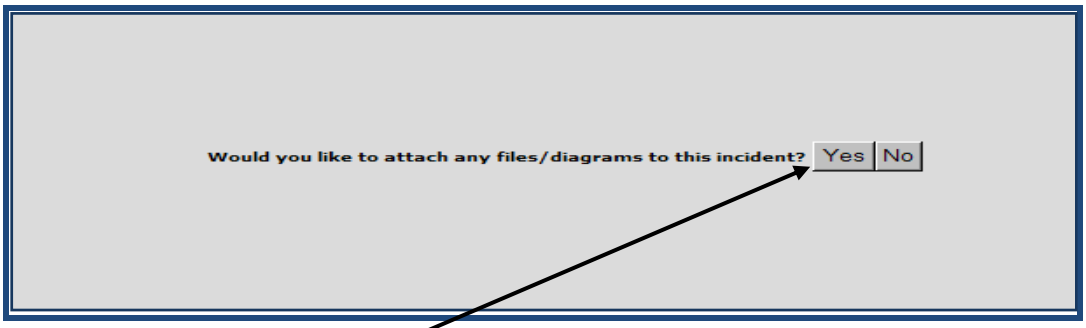


EXAMPLES of the following screens:



- When you are finished entering in the information, click **SUBMIT**. If any of the required fields are missing, they will be highlighted in yellow and must be filled in before you will be able to submit the incident report.

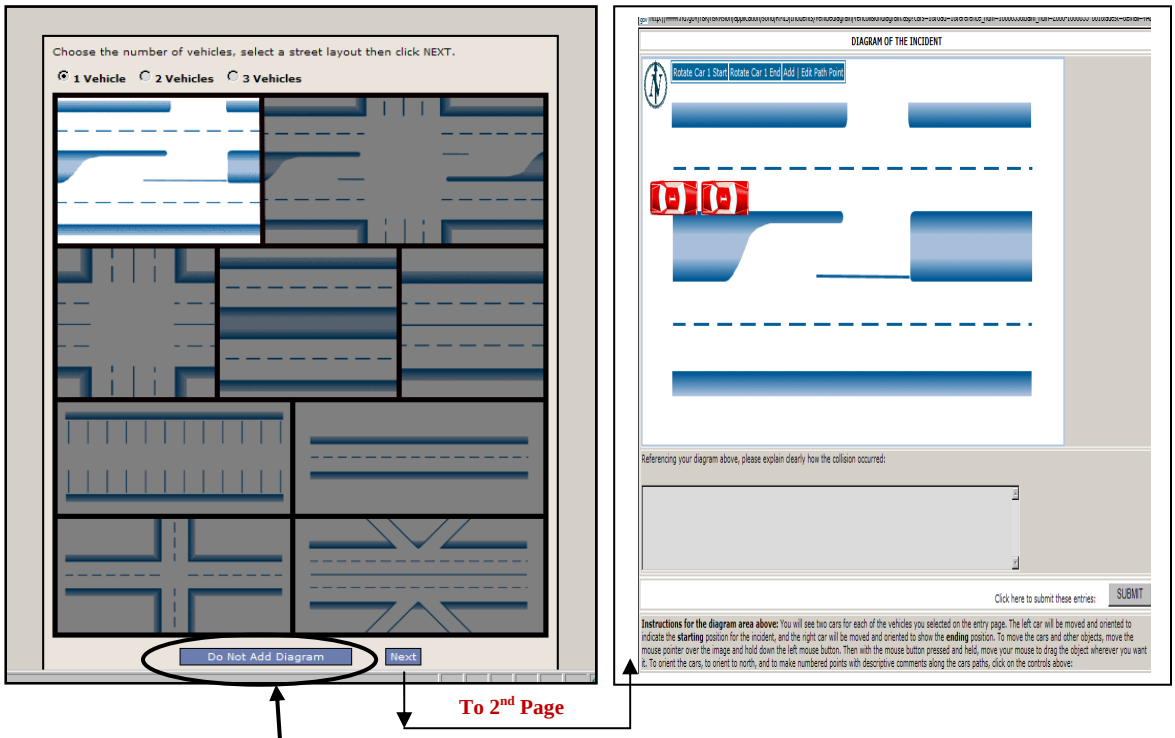
- The next screen allows you to attach documents/pictures and submit them with the incident report.



- To attach documents, emails, diagrams, pictures, etc. you will need to select Yes.

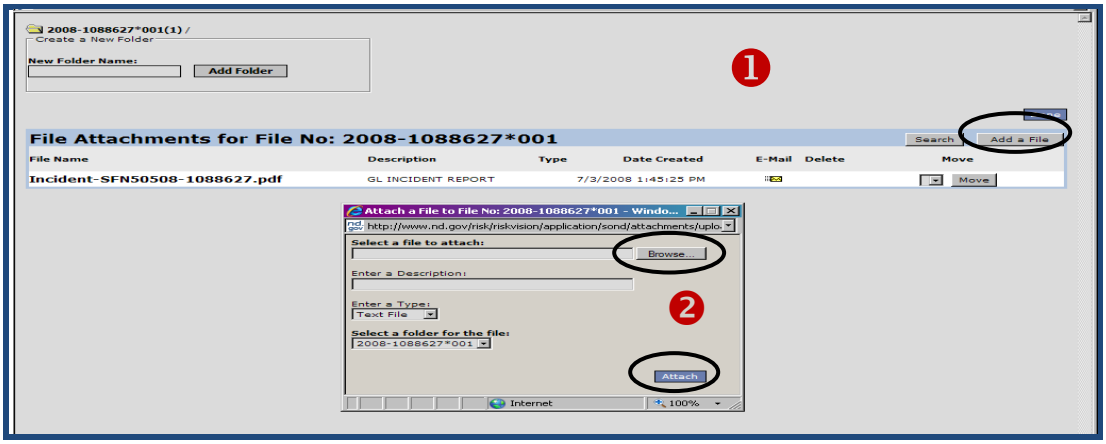
- The first option available is to prepare a **Vehicle Diagram**. If that applies to your incident/accident, then complete the diagram. Separate instructions for the vehicle diagram feature are at Vehicle Diagram Instructions.

EXAMPLE of Vehicle Diagram pages.

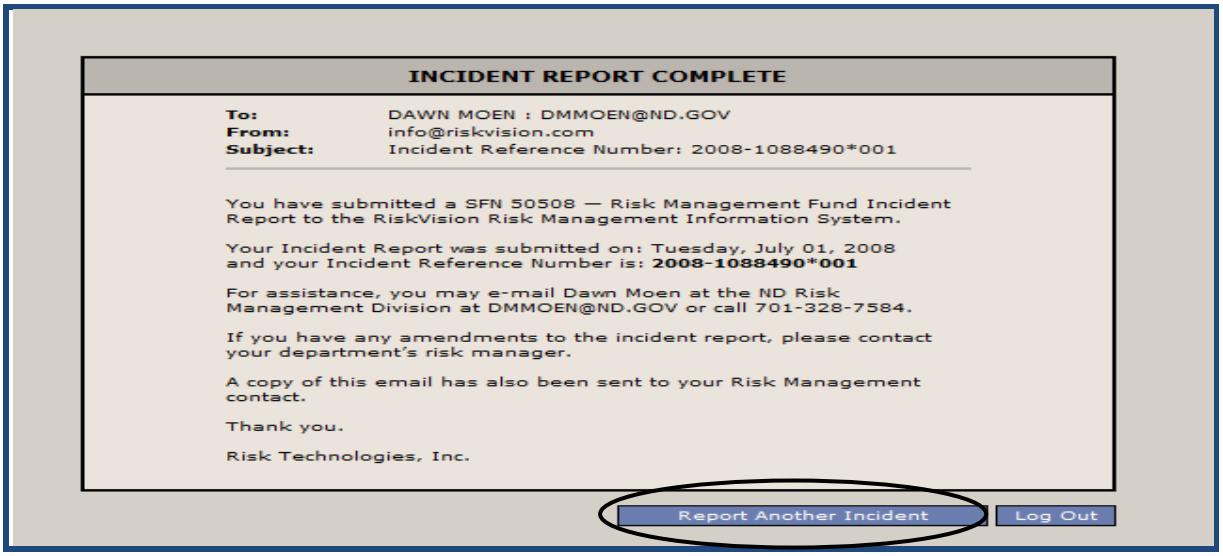


- If the Vehicle Diagram option does not apply to your incident/accident, select "**Do Not Add Diagram**".

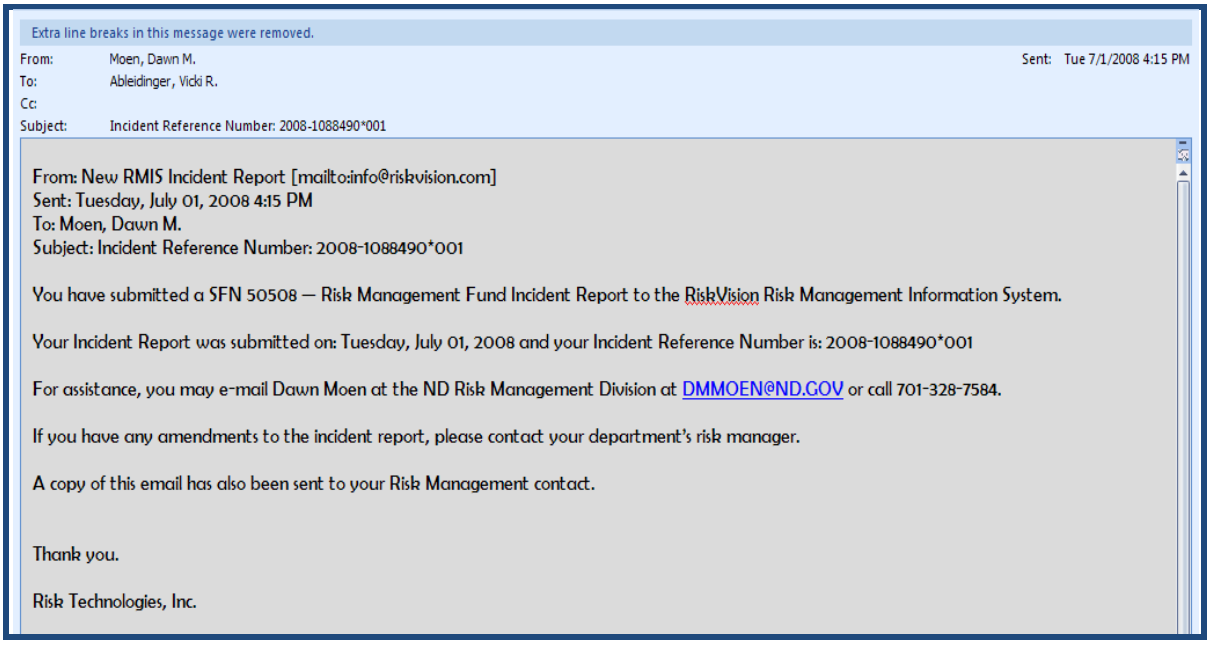
- The next screens are identified by ❶ and ❷, which will take you through the steps to "**Add a File**", locate it ("**Browse**"), and "**Attach**" it.



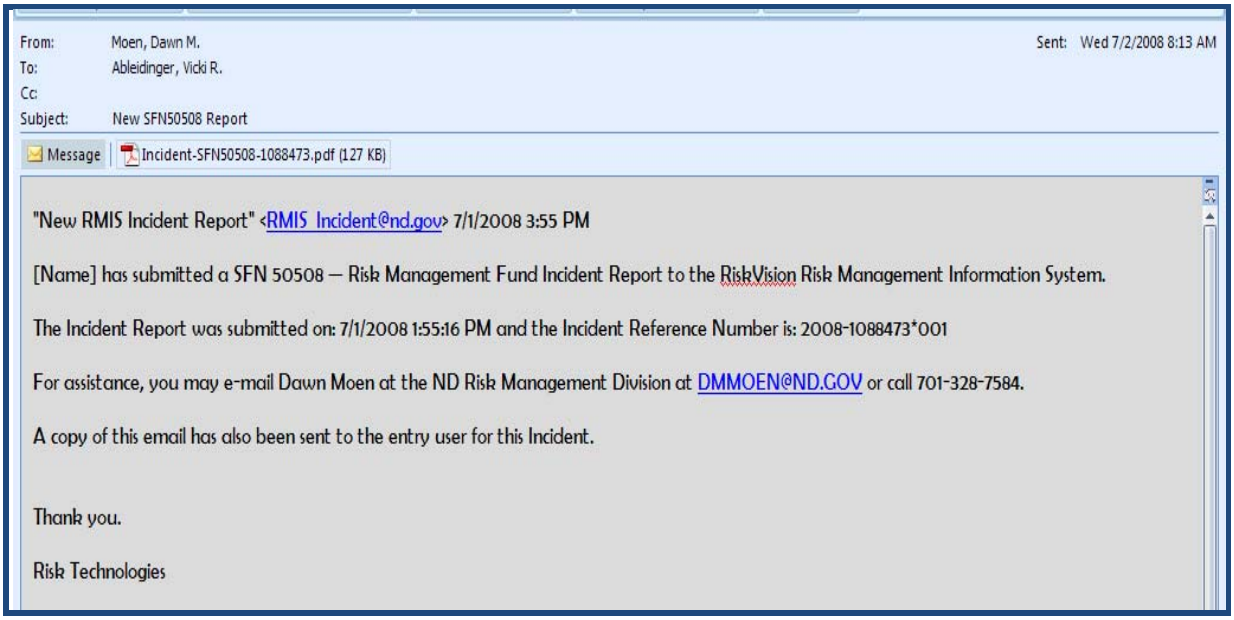
- After attaching files or choosing not to, the next screen will confirm that the report was submitted successfully. You also have the option to submit another report without entering the user's contact information again.



- The entry user will get an email confirming that he/she has submitted the incident report.



- After Risk Management has reviewed the incident report, the entity's Risk Management or Workers Compensation contact will also receive an email with a file attachment. The incident can be reviewed and copied by opening the attached pdf file from the email. However, the copy should be shredded once it appears on the entity's loss run report.



From: Moen, Dawn M. Sent: Wed 7/2/2008 8:13 AM
To: Ableidinger, Vicki R.
Cc:
Subject: New SFN50508 Report
Message | Incident-SFN50508-1088473.pdf (127 KB)

"New RMIS Incident Report" <RMIS_Incident@nd.gov> 7/1/2008 3:55 PM

[Name] has submitted a SFN 50508 – Risk Management Fund Incident Report to the RiskVision Risk Management Information System.

The Incident Report was submitted on: 7/1/2008 1:55:16 PM and the Incident Reference Number is: 2008-1088473*001

For assistance, you may e-mail Dawn Moen at the ND Risk Management Division at DMMOEN@ND.GOV or call 701-328-7584.

A copy of this email has also been sent to the entry user for this Incident.

Thank you.

Risk Technologies

The sample forms on the following pages are composite screen shots showing all of the sections of the fields requesting information in the System. These on-line forms will appear different than the paper forms you are familiar with (SFN 50508). However, when you have successfully completed this process, the System will automatically process the information entered into the fields and generate the report form exactly like the paper form, which will be sent by email to the Risk Management or Workers Compensation Contact.

SFN 50508 – INCIDENT REPORT

Department/Agency Where Incident Occurred | **Claim Form Requested** | **Destruction Hold Notice** | **Incident Type**

Date of Incident | **Day of Week** | **Time of Incident** | **Employment Practices**

Address where incident occurred and description of location (building, street, city, highway, mile, marker, etc.)

Street Address 1 | **Street Address 2** | **City** | **State** | **Zip**

Location Description

Weather Conditions

Description of incident (be specific):

a. What happened? *(limited to 1000 characters)*

b. How did it happen? *(limited to 200 characters)*

If Injury, Cause of Injury

[+] add injured

INJURED PARTICIPANT #1

Primary | **Bodily Injury** | **Last Name** | **First Name** | **M.I.** | **Date of Birth** | **Sex** | **Individual Status** | **WC Claim Filed?**

Street Address 1 | **Street Address 2** | **City** | **State** | **Zip** | **Phone #**

Describe Injury | **Request Ergonomic Evaluation**

Body Part | **Injury Type**

[+] add owner

PROPERTY OWNER

Primary | **Property Damage** | **Owner's Last Name** | **First Name** | **M.I.**

Owner's Street Address 1 | **Street Address 2** | **City** | **State** (ND) | **Zip** | **Phone #**

What was damaged? | **Where can damaged property be seen?** | **State property damaged?**

[+] add witness

WITNESS #1

Witness Last Name | **First Name** | **M.I.**

Street Address 1 | **Street Address 2** | **City** | **State** | **Zip** | **Phone #**

Describe policies and procedures in effect that relate to this incident.

Were policies and procedures followed?

List all causes of incident (equipment, procedure, environment, behavior)

Has corrective action been initiated?

If yes, what corrective action is being taken? If no, when will corrective action be taken?

Work Order Submitted

What safety equipment/training could have prevented this injury?

Comments

Report Prepared By (Name of State Employee) | **Title** | **Phone #** | **Date**

Agency Risk Management Contact | **Phone #** | **Date**

Date Submitted to Risk Management | **Date Submitted to Loss Control** | **Date Reviewed by Loss Control**

SFN 51301 – MOTOR VEHICLE ACCIDENT REPORT

Department/Agency Where Incident Occurred | Claim Form Requested | Destruction Hold Notice

AGENCY
Agency Name | District/Division | Phone #
Street Address 1 | Street Address 2 | City | State | Zip

TIME
Date of Accident | Day of Week | Hour

LOCATION
Highway Number | Posted Speed Limit | Location From Nearest City
City | Street | At Intersection With

TYPE
Accident Type

STATE VEHICLE NO. 1
Year | Make | Model | Unit Number | Citation Issued | Est. Speed | Direction Traveling
Driver Last Name | First Name | M.I. | License Number | Work Phone # | Home Phone #
Street Address 1 | Street Address 2 | City | State | Zip
Driver Injured | Describe Injury | Workers' Comp Claim Filed?
Damage (List Parts) | Estimate

[+] add passenger
ADD STATE VEHICLE PASSENGER
Passenger Last Name | First Name | M.I. | Work Phone # | Phone # | Injured | Killed
Street Address 1 | Street Address 2 | City | State | Zip

OTHER VEHICLES
[+] add vehicle
OTHER VEHICLE & DRIVER #1
Primary | Year | Make | Model | License Plate | State | Citation Issued | Direction Traveling
Driver Last Name | First Name | M.I. | License Number | Work Phone # | Home Phone #
Street Address 1 | Street Address 2 | City | State | Zip
Driver Injured | Describe Injury | Damage (List Parts) | Estimate
Owner's Insurance Company | Policy Number | Phone #
Street Address 1 | Street Address 2 | City | State | Zip
Drivers's Insurance Company | Policy Number | Phone #
Street Address 1 | Street Address 2 | City | State | Zip

[+] add passenger for this vehicle
OTHER VEHICLE PASSENGER
Passenger Last Name | First Name | M.I. | Work Phone # | Phone # | Injured | Killed
Street Address 1 | Street Address 2 | City | State (ND) | Zip

WITNESSES
[+] add witness
WITNESS
Witness Last Name | First Name | M.I.
Street Address 1 | Street Address 2 | City | State (ND) | Zip | Phone #

DAMAGE TO OTHER PROPERTY
[+] add owner
PROPERTY OWNER
Primary | Owner's Last Name | First Name | M.I. | Work Phone # | Phone #
Owner's Street Address 1 | Street Address 2 | City | State (ND) | Zip
What | Estimate

KILLED/INJURED
[+] add injured
INJURED PARTICIPANT
Primary | Injured Last Name | First Name | M.I. | Work Phone # | Phone #
Street Address 1 | Street Address 2 | City | State (ND) | Zip
Nature and Extent of Injury

CONDITIONS
Weather | Roadway | Did Vehicle Have Any Defects?
Were Seat Belts in Use? | Were Lights On?

REPORT
Accident Reported To Law Enforcement? | Vehicle Dispatch Office or DOT Repair Location

Explain How Accident Occurred *(limited to 1000 characters)*

State Employee | Department | Phone #
State Employee Completing Report | Phone # | Date | Date Submitted to Risk Management

SFN 53601 – MEDICAL SERVICES INCIDENT REPORT

Department/Agency Where Incident Occurred | Claim Form Requested | Near Miss

Date of Incident | Day of Week | Time of Incident | Employment Practices

Last Name | First Name | M.I. | Sex | Date of Birth | ID Number | Status

Street Address 1 | Street Address 2 | City | State | Zip | Phone #

Service Area | Ward | Physician Notified? | Family Notified? | Workers' Comp Claim Filed?

WITNESS

Witness Last Name | First Name | M.I.

Street Address 1 | Street Address 2 | City | State (ND) | Zip | Phone #

Date Reviewed by Loss Control | Property DMG | What:

Occurrence Category (select one main category and one sub category)

Main Category: | Sub Category:

Part of Body Injured | Bilateral ☐ Left ☐ Lower ☐ Middle ☐ Right ☐ Unknown ☐ Upper ☐

Bodily Injury

- ABRASION/SCRAPES
- AMPUTATION
- ANOREXIA/RESP DISTRESS
- BITE INTACT SKIN
- BITE BROKEN SKIN
- BLISTER
- BURN FIRST DEGREE
- BURN SECOND DEGREE

> <

Selected Bodily Injury

- SPRAIN/STRAIN

Area of Occurrence | Process

Description of Incident *(limited to 1000 characters)*

Describe policies and procedures in effect that relate to this incident.

Were policies and procedures followed?

List all causes of incident (equipment, procedure, environment, behavior)

Has corrective action been initiated?

If yes, what corrective action is being taken? If no, when will corrective action be taken?

Work Order Submitted

What safety equipment/training could have prevented this injury?

Comments

Individual Preparing Report | Title | Date

Dept. Head/Supervisor | Title | Date

Additional Sign-Off | Title | Date

Risk Management Review | Title | Date | Date Submitted to Risk Management